STATE FARM INDEMNITY COMPANY
STATE FARM GUARANTY INSURANCE COMPANY

PERSONAL INJURY PROTECTION BENEFITS

CONDITIONAL ASSIGNMENT OF BENEFITS

(FOR ACCIDENTS OCCURRING ON AND AFTER 11/1/2011)

Policy Number _____ **Claim Number:** _____

Patient's Name: _

I authorize and request State Farm Indemnity Company/State Farm Guaranty Insurance Company ("State Farm") to pay directly to the above-named medical provider, the amount due to me under the terms of the above-referenced policy as a result of medical care rendered by that medical provider and all medical staff associated with the provider's office.

_____ Date:_____

Patient's Signature or Parent/Legal Guardian

I have read the information contained in the State Farm informational letter concerning the Decision Point Review Plan, including Medical Services Review, Decision Point Review and precertification requirements (collectively the "Plan") and, as a condition precedent to State Farm's acceptance of this assignment, I agree for myself, and on behalf of all medical staff associated with my office, to the following:

1) I (We) will comply with all the procedures of the Plan.
2) I (We) will initiate all Pre-certification and Decision Point Review requests as required by the Plan.
3) In the event that I (we) fail to comply with the conditions of the Plan, and such failure results in the imposition of a co-payment penalty, I (we) will hold the patient harmless for such co-payment penalty insofar as I (we) will not seek payment from the patient for any unpaid portion of the medical services arising from such co-payment penalty.
4) I (We) will submit disputes as defined in the Plan to the Internal Dispute Resolution Process set forth therein. After final determination, submission of disputes not resolved by the Internal Dispute Resolution process to the Personal Injury Protection Dispute Resolution process set forth in N.J.A.C. 11:3-5.
5) I (We) will submit all disputes not subject to the Internal Dispute Resolution process to the Personal Injury Protection Dispute Resolution process set forth in N.J.A.C. 11:3-5.
6) I (We) will submit medical records with clinically supported findings to support the diagnosis, causal relationship to the accident and care plan.
7) I (We) will comply with a request to (i.) submit to an examination under oath, and (ii.) provide the Company with any other pertinent information/documentation that it requests.
8) I (We) agree not to pursue payment directly from the patient, with the exception of deductibles and co-payments. I (We) may revoke the assignment, and I (we) shall be entitled to pursue payment from the patient, when benefits are not payable due to lack of coverage and/or violation of a policy condition by the patient.

I (we) agree that State Farm's Assignment of Benefits is the only valid assignment of benefits. I (we) agree that State Farm has the right to reject, terminate or revoke this assignment of benefits. I (we) agree that this assignment of benefits may require State Farm's written consent.

Ketan Vora
_____ Date: _____

Provider's Signature

Ketan D. Vora, D.O. TIN Number: 45-2741386

Provider's Name (Please Print)

Provider's Address: Non Surgical Orthopedics of New Jersey, PC
400 Route 34, Suite A, Matawan, NJ 07747